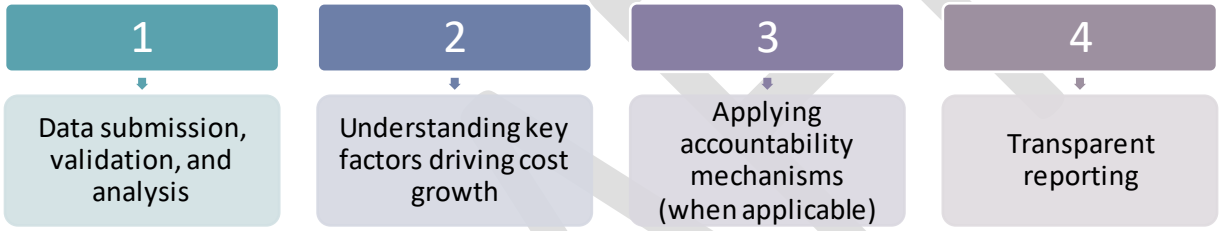
OREGON'S HEALTH CARE COST GROWTH TARGET PROGRAM ANNUAL PROCESS

INTRODUCTION

The Oregon Health Authority intends to take a collaborative approach to implementing Oregon's cost growth target program, including working in partnership with payers and provider organizations to help everyone achieve the cost growth target and improve health care affordability.

This document describes the health care cost growth target program's annual process. The process is multi-faceted and iterative, with payer and provider organization involvement throughout. The annual process can be grouped into four key steps:



This document unpacks each of these steps and provides details about OHA, payer and provider organization roles. This is a working document and OHA anticipates that these details will continue to be clarified and this document will be developed throughout program implementation in 2021.

Based on Implementation Committee feedback in November, this document:

- Clarifies OHA's intent to focus the program on collaboration
- Clarifies terminology
- Expands on each of the process steps and timing
- Provides details about OHA and payer / provider organization roles
- Adds detail about compliance with data submission requirements
- Clarifies Performance Improvement Plan (PIP) processes

A placeholder is left in the document for escalating accountability mechanisms, pending the Implementation Committee's December 16th discussion.

Please contact HealthCare.CostTarget@dhsoha.state.or.us with any questions or comments about this draft document.

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IMPLEMENTATION COMMITTEE CHARGE

Senate Bill 889 (2019) directs the Implementation Committee to recommend accountability and enforcement processes, which may be phased in over time, including:

- Measures to ensure compliance with reporting requirements;
- Procedures for imposing a performance improvement action plan or other escalating enforcement actions when a provider or payer fails to remain at or below the benchmark; and
- Measure to enforce compliance with the health care cost growth benchmark in programs administered by the Oregon Health Authority and the Department of Consumer and Business Services, including, but not limited to:
    - The medical assistance program
    - Medical, dental, vision and other health care benefit plans offered by PEBB
    - Medical, dental, vision and other health care benefit plans offered by OEBB
    - Insurance offered through the health insurance exchange; and
    - The review of health insurance premium rates by DCBS

SB 889 specifies that "Annually, the program shall for providers and payers for which health care cost growth in the previous calendar year exceeded the health care cost growth benchmark: (A) analyze the cause for exceeding the health care cost growth benchmark; and (B) if appropriate, require the provider or payer to undertake a performance improvement action plan."

Governor Brown also directed the Implementation Committee to ensure "robust enforcement and accountability tools are recommended to hold health insurance carriers and providers accountable for meeting the target" (Oct 2019 letter).

OHA INTENT

The Oregon Health Authority intends to take a collaborative approach to implementing Oregon's cost growth target program, including working in partnership with payers and provider organizations to help everyone achieve the cost growth target and improve health care affordability.

OHA intends to establish a collaborative data and information sharing process between the state and payer and provider organizations with the goal that the state and the payer or provider organization comes to common agreement about whether a payer or provider organization was above or below the cost growth target in a given year and the why.

OHA intends for any escalating accountability mechanisms to apply as a last resort only after transparency and collaborative efforts to contain costs are not having an impact.

TERMINOLOGY

Accountability and Enforcement

Implementation Committee members noted at the November meeting that "accountability and enforcement" have different meanings, despite SB 889 treating them as synonyms.

Moving forward, staff propose only using "accountability" to refer to the combination of strategies and processes under consideration by the Implementation Committee to apply when a payer or provider organization does not meet the health care cost growth target.

Justified and Unjustified

Implementation Committee members also shared concerns with using "justified" and "unjustified" as designations for a payer or provider organization's reasons for health care cost growth that exceeds the target, including the perceived unilateral judgement in these terms.

Moving forward, staff propose using the following terms to refer to a payer or provider organization's rationale for why they may have not met the target in a given year: "reasonable" and "unreasonable."

See section 2.3 for more detail on what factors will be taken into consideration in determining whether a payer or provider organization's cost growth is reasonable.

HEALTH CARE COST GROWTH TARGET PROGRAM PROCESS

STEP 1: DATA SUBMISSION, VALIDATION, ANALYSIS

1.1 DATA SUBMISSION

1. OHA works with the to be established Health Care Cost Growth Target Technical Advisory Group (TAG) to develop and review the data submission template and specifications.

2. OHA publishes the data submission template, specifications, and deadlines for data submission on its website and notifies data submitters.

3. OHA holds webinars and offers office hours / technical assistance about the data submission.

4. Payers submit aggregated data to OHA should their membership size meet thresholds. *Provider organizations do not submit data.*

THRESHOLD FOR DATA SUBMISSION

All payers and TPAs with at least 1,000 covered Oregon lives across all lines of business.

For any payers who meet thresholds to submit data, and do not submit data in a given year -- see Failure to Submit Data section below.

Timing: data submission will occur after the close of a measurement year. For example, payers will be asked to submit data for the CY 2021 measurement year in CY 2022. Exact dates TBD but will allow approximately 6 month of claims runout following the close of the measurement year. OHA will discuss options for claims runout periods with the TAG in early 2021.

Timing for all the other steps in the process are anchored to the data submission deadline . See Figure 1.

1.2 DATA VALIDATION

1. OHA conducts initial data validation, which will include data completeness and quality checks, as well as reviewing any outlying trends and assessing face validity.

2. OHA notifies payers once the review has been completed, which will include whether the data submission is complete, and whether any questions were identified in the initial data validation.

3. If applicable, OHA asks payers to resubmit data or clarify data or provide additional documentation to address any questions from the initial data validation.

For any payers who do not resubmit or provide requested documentation related to their data submission -- see Failure to Submit Data section below.

Timing: data validation will occur immediately upon data submission, with defined timeframes for each step (e.g. OHA will complete initial data validation and notify payers of any questions or requests for resubmission within x days). Payers will have another defined timeline to respond to any questions or resubmit data (e.g. within y days of OHA's request). OHA will have a target date for having complete and final data before moving into data analysis (step 1.3).

FAILURE TO SUBMIT DATA

OHA will establish administrative rules for the required data submission for the cost growth target program in 2021 under its statutory authority to collect cost and quality data from insurers (ORS 442.373 and 442.386). Under these administrative rules, if a payer who meets the membership size thresholds for data submission does not meet the established reporting requirements (including timeliness of submission and completeness of submission), OHA may impose financial penalties.

OHA intends to align these civil penalties with those used in the All Payer All Claims (APAC) data program, as codified in OAR 409-025-0150.[1]

OHA will provide payers with written notification of each failure to comply with data submission requirements prior to imposing any civil penalties. Payers will have 30 calendar days to come into compliance with the data submission requirements. If payers do not come into compliance after 30 days, OHA will impose civil penalties of at least $100 / day and potentially increasing to $500 / day, depending on the degree of non-compliance with the data submission requirements.

Note the APAC program has not yet imposed civil penalties on any mandatory data reporters; all data reporters have come into compliance after the written notification has been issued.

1.3 DATA ANALYSIS

1. OHA uses payer data submissions to calculate annual cost growth at the state level, by market, for each payer, and for provider organizations. *Note that payers will be doing some of these calculations in preparing the required data submission and will have insight into their own performance relative to the cost growth target as they develop their data submission. OHA will be using the payer submitted data and aggregating it to calculate cost growth performance at the state, market, and provider organization levels.*

2. OHA identifies which payers and provider organizations meet the minimum size thresholds for public reporting in a given year. OHA will notify these payers and provider organizations and share the results of the data analysis and statistical testing prior to publication (below).

[1] https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=258324

THRESHOLDS FOR PUBLIC REPORTING

- Any payer and TPA with at least 5,000 lives in a line of business.
- Provider organizations with at least 10,000 unique all payer lives *or* at least 5,000 unique lives under any one line of business.

Timing: OHA will have a defined period of time to calculate annual cost growth and identify which payers and provider organizations meet the minimum size thresholds for public reporting. OHA will have a target date (TBD) to share the results of the analysis and testing with payers and providers.

1.4 STATISTICAL TESTING

OHA will be statistically testing performance against the cost growth target to ensure confidence with stakeholders and the public that any payers or provider organizations that are identified as failing to meet the cost growth target are exceeding the cost growth target.

Oregon is taking a rigorous and conservative approach to identifying payers and provider organizations' performance relative to the target through this step, allowing OHA to take an active approach to accountability.

OHA has been developing a detailed document describing the statistical testing methodology; that content will be combined with this document in the future.

1. OHA applies statistical testing for payers and provider organizations for all lines of business and for each line of business to determine which category each payer and provider organization falls into for the performance year:

1	Achieved the target; positive recognition
2	Unable to determine performance relative to the target with statistical confidence; not subject to accountability mechanisms
3	Exceeded the target, triggering a 1:1 conversation; may be subject to accountability mechanisms

2. Payers and provider organizations will be included in the third category for any of the following results of the statistical testing:

    - if a difference between a payer or provider organization's performance and the cost growth target can be detected at 95% confidence
    - if a difference can be detected at 80% confidence for two consecutive years
    - if a difference can be detected at 80% confidence in 3 out of 5 years

See Appendix for examples of how the statistical testing will be applied across multiple years to determine payers or provider organizations in the third category.

3. OHA will hold webinars and/or office hours with payers and provider organizations to explain the statistical testing process and results.

Timing: OHA will have a defined period of time to conduct the statistical testing and share results with payers and provider organizations. This period may be longer in the initial years of data submission.

1.5 PAYER AND PROVIDER ORGANIZATION REVIEW

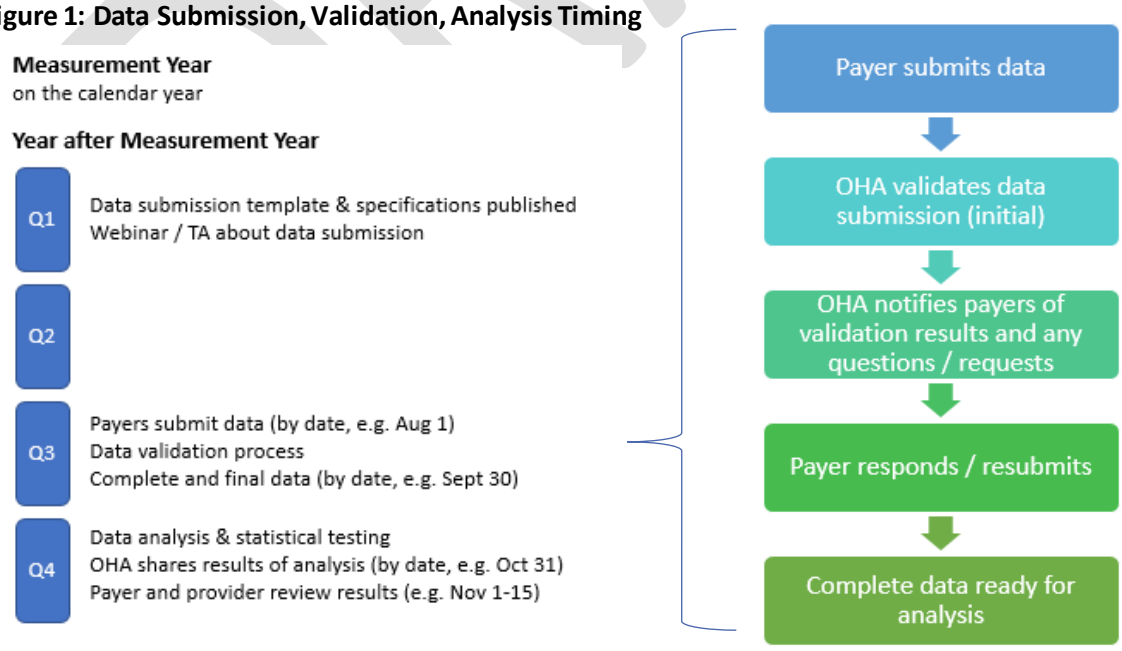
1. OHA shares results of the data analysis and statistical testing with payer and provider organizations, including which of the three above categories they fall in.

2. Payers and provider organizations have opportunity to review the analysis. If payers and provider organizations have questions or concerns about OHA's analysis or statistical testing results, they should be raised at this point and addressed. Provider organizations may also have specific questions for the payers; OHA will help facilitate these conversations.

Note: OHA intends to follow Rhode Island's approach of sharing and reviewing results with the payers first and ensuring data are correct, before sharing and reviewing with provider organizations.

Timing: OHA will establish a clear timeline for the review period (e.g. payers and provider organizations will be asked to submit any questions or concerns within xx days after receiving the results of the data analysis and statistical testing). See Figure 1 below for an example of timing; some steps in the process may take longer in initial years.

Figure 1: Data Submission, Validation, Analysis Timing



STEP 2: UNDERSTANDING KEY FACTORS DRIVING COST GROWTH

2.1 INITIAL CONVERSATIONS TO UNDERSTAND PERFORMANCE

OHA schedules 1:1 conversation with any payers and provider organizations that OHA found to have exceeded the target following statistical testing. At 1:1 conversation:

- OHA shares its findings and any interpretations, including identification of key factors that may have caused cost growth to exceed the target that year based on its independent analysis.
- Payers and provider organizations share any supplemental data that sheds light on factors that influenced cost growth performance, and potential interpretations, including key factors that may have caused cost growth to exceed the target that year.

Timing: OHA will begin scheduling these conversations after the results of the data analysis and statistical testing are shared and as any questions or concerns about the analysis and statistical testing are addressed (see step 1.5 above). Any conversations about the analysis and statistical testing may naturally flow into these conversations to understand performance.

2.2 ITERATIVE CONVERSATIONS

Initial 1:1 conversation may identify additional needed analysis or questions to be answered by OHA and/or the payer or provider organization. Follow up and additional conversations may be needed.

Timing: the need for additional conversations or conversations with additional parties will vary.

2.3 DETERMINATION OF REASONABLENESS

When OHA and the payer or provider organization have identified key factors that caused cost growth to exceed the target that year in the conversations described above (Steps 2.1 and 2.2), OHA will determine if exceeding the cost growth target was or was not reasonable based on consideration of potentially substantiating factors, and the payer or provider organization perspective.

This determination will inform whether the payer or provider organization should therefore be held accountable for that year's performance (see Step 3).

WHAT FACTORS WILL BE TAKEN INTO ACCOUNT IN DETERMINATION?

A mix of factors may be the cause of cost growth, including factors that cannot be anticipated (e.g., COVID-19). Some of the potential factors that may cause an organization to reasonably exceed the target in a given year include, but are not limited to:

- Changes in mandated benefits
- New pharmaceuticals or treatments / procedures entering the market

- Changes in taxes or other administrative factors
- "Acts of God" – natural disasters, pandemics, other
- Changes in federal or state law
- Investments to improve population health and/or address health equity

The isolated impact of the identified factor, or the combination of identified factors must be significant enough to have caused the payer or providers cost growth to exceed the target. Factors must be completely outside of the control of the payer or provider organization and may be environmental, market-based, or governmental in nature.

However, not all factors can be predicted, so this will not be a fixed list of criteria, but rather an opportunity to understand what has happened during the year.

1. If a payer or provider organization disagrees with OHA's determination, the payer or provider organization will be able to appeal. An appeals process will be developed in 2021 so it can be applied when we work through this process for the first performance year (CY 2021) in 2022.

2. Payers and provider organizations who exceed the target but are NOT subject to any accountability mechanisms for that year's performance after OHA's determination will be identified as such in public reporting, with appropriate context. See Step 4 below.

Timing: OHA will have a target date for completing all 1:1 conversations and reaching determination of reasonableness of cost growth for that performance year.

STEP 3: APPLYING ACCOUNTABILITY MECHANISMS (when applicable)

The Oregon Health Authority intends to take a collaborative approach to implementing Oregon's cost growth target program, including working in partnership with payers and provider organizations to help everyone achieve the cost growth target and improve health care affordability.

Accountability mechanisms are only applied to payers or provider organizations with unreasonable cost growth about the cost growth target (which may be for a given line of business, or for all lines of business), as determined in step 2 above. OHA expects that every year there will be payers and provider organizations whose cost growth is above the target, but for a reasonable reason that does not result in the application of accountability measures described in this section.

SB 889 requires the Implementation Committee to consider in its recommendations possible escalating accountability mechanisms for exceeding the cost growth target in addition to Performance Improvement Plans. This section describes Performance Improvement Plans; other escalating accountability options will be discussed by the Implementation Committee at its December 16th meeting (see Escalating Accountability Options document).

3A: Performance Improvement Plans

Performance improvement plans (PIPs) are required by SB 889. "Annually, the program shall (c) for providers and payers for which health care cost growth in the previous calendar year exceeded the health care cost growth benchmark: (A) Analyze the cause for exceeding the health care cost growth benchmark; and (B) if appropriate, require the provider or payer to undertake a performance improvement action plan."

PIPs will be automatically triggered for any payer or provider organization that OHA determines has unreasonably exceeded the cost growth target during any performance year for one or more lines of business. OHA will retain discretion to waive PIP requirements in recognition of this being a new program, or for unforeseen market conditions. Any waiving of PIP requirements for a given performance year would be equitably applied to all payers or provider organizations experiencing the market condition or other factor leading to the waiver.

3.1 PAYER OR PROVIDER ORGANIZATION IS NOTIFIED OF PIP REQUIREMENT

1. Following the determination that the payer or provider organization is subject to accountability mechanisms for a given performance year (step 2.3 above), OHA will notify the payer or provider organization that they are required to submit a performance improvement plan.

2. OHA will provide the performance improvement plan template, guidelines, and timeframe for the payer or provider organization to submit the PIP and schedule a call to explain expectations and how OHA will collaborate with the organization in PIP development.

Timing: OHA will notify the payer or provider organization of the requirement to submit a PIP shortly after determination (which will have a target date each year, see section 2.3 above). The notification will also include the timeline for PIP development and PIP submission date.

GENERAL PARAMETERS FOR PIPS

PIPs must be centered on identified key cost growth drivers and develop concrete action steps to address these cost growth drivers in any identified lines of business.

PIPs must identify an appropriate timeframe by which the payer or provider organization will reduce such cost growth drivers and be subject to evaluation by OHA consistent with the identified timeframe.

PIPs should have clear metrics for success, to be used for evaluation of PIP progress and completeness.

PIP implementation may extend for more than one year, however, payer and provider organization performance relative to the cost growth target will continue to be assessed annually, and payers and provider organizations will be expected to achieve the cost growth target each year during the PIP implementation period.

3.2 PIP DEVELOPMENT

OHA wants to ensure that performance improvement plans have integrity and will provide a basis for future evaluation of performance. Payer or provider organizations developing PIPs will benefit from understanding OHA's expectations. It is important to create space for OHA to collaborate with payers and providers in developing PIPs.

1. OHA will offer technical assistance to payers and provider organizations that are required to submit a PIP. This may include webinars or office hours, individual consultation with technical assistance providers or staff, or other guidance.

2. Payers and provider organizations that are required to submit a PIP will have a contact(s) at OHA with whom they can work in developing their PIPs.

3.3 PIP SUBMISSION

1. The payer or provider organization will submit a PIP to OHA in accordance with the published guidelines using the specified template and within the specified timeframe.

2. If payers or provider organizations fail to submit their PIP in a timely and complete manner, they may be subject to financial penalties (see Failure to Develop a Performance Improvement Plan below).

3.4 PIP REVIEW AND APPROVAL

1. OHA will review the submitted PIPs for completeness and compliance with PIP requirements (see Step 3.2). OHA will also review the submitted PIPs with an eye toward feasibility and quality of the proposed PIP, including likelihood of success and anticipated timelines. OHA may involve partners, such as DCBS, in reviewing the PIPs.

2. OHA may have questions for the payer or provider organization about their PIP, or may ask them to submit supplemental or clarifying information, or resubmit their PIP if it is incomplete or fails to meet the established guidelines. OHA will make staff and/or technical assistance resources available to payers and provider organizations if required to resubmit their PIPs.

3. If payers or provider organizations fail in a timely and complete manner to respond to questions about their PIP, or to submit requested information, or to resubmit their PIP if needed, they may be subject to financial penalties (see Failure to Develop a Performance Improvement Plan below).

4. OHA will notify payers and provider organizations that their PIPs have been approved.

5. OHA will post final, approved PIPs online to continue to support program transparency.

3.5 PIP IMPLEMENTATION AND REPORTING

1. Payers and provider organizations will work to implement their PIPs. Payers and provider organizations may be invited to participate in or may form learning collaboratives or other learning opportunities to further their improvement projects.

2. OHA will provide payer and provider organizations with a reporting template and timeline to provide updates on their PIP implementation progress. OHA will offer technical assistance on PIP reporting to payers and provider organizations. This may include webinars or office hours, individual consultation with technical assistance providers or staff, or other guidance

3. Payers and provider organizations will submit regular reports as requested by OHA on their progress implementing their PIPs. Failure to submit required reports may result in financial penalties (see below).

4. If OHA is concerned that a payer or provider organization is not demonstrating a good faith effort to implement their PIP, or if activities proposed in the PIP are not being completed and/or significant milestones are not being met, as evidenced through the regular reports or other sources, OHA will reach out to the payer or provider organization to understand the circumstances, and may impose compliance penalties (see below).

3.6 PIP EVALUATION

1. Payers and provider organizations will submit a final report on their PIP to OHA using established templates and timelines. Final PIP reports may be publicly posted.

2. OHA will review final PIP reports to understand if the payer or provider organization successfully completed the PIP activities as outlined, met their established success metrics or not, and to understand if the PIP has had an impact on reducing or eliminating the cost growth drivers that were originally identified.

FAILURE TO DEVELOP A PERFORMANCE IMPROVEMENT PLAN

OHA may impose compliance penalties on payers and provider organizations for not meaningfully engaging with OHA in the development and implementation of a Performance Improvement Plan. Meaningful engagement may include the following:

- Meeting with OHA staff to discuss and develop PIPs
- Responding to requests for information about PIPs
- Submitting PIPs using the required templates and in accordance with the established timelines
- Completing and submitting regular reports on PIP implementation and progress
- Demonstrating a good faith effort to implement and complete PIPs

If the payer or provider organization is not willing to meaningfully engage with OHA in the development and implementation of the PIP and required PIP reporting, OHA may impose penalties not to exceed $500 per day. OHA will provide written notification of any failure to meet requirements prior to imposing any civil penalties. Payers and provider organizations will have 30 calendar days to come into compliance with any requirements.

For reference: Massachusetts' statutory requirements for Performance Improvement Plans, Chapter 224, Section 10 (2012). https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224

3B: Escalating Accountability Mechanisms

To be added after Implementation Committee discussion and recommendation at their December 16th meeting. See Escalating Accountability Options document.

STEP 4: TRANSPARENT REPORTING

Transparency supports accountability in and of itself and the Committee has recommended approaches for public reporting and public hearings on performance relative to the cost growth target. Transparency is fundamental for the success of Oregon's health care cost growth target program.

4.1 PUBLIC REPORTS

1. OHA will report the performance relative to the cost growth target of all payer and provider organizations that meet criteria for public reporting:

    - Any payer and TPA with at least 5,000 lives in a line of business
    - Any provider organization with at least 10,000 unique all-payer lives, or at least 5,000 unique lives under any one line of business.

2. Payers and provider organizations will have advance notice whether or not they are subject to public reporting for a given year (see section 1.3). Note: OHA does not anticipate that the list of payers and provider organizations subject to public reporting will change much year over year.

3. OHA will report the performance of all payer and provider organizations that meet the above criteria using the three categories described in section 1.4.

Category		In Public Report
1	Achieved the target	Highlight success, best practices
2	Unable to determine performance relative to the target with statistical confidence	Be clear that OHA cannot say with certainty whether these payers or provider orgs met or exceeded the cost growth target
3	Exceeded the target	Differentiate between those with substantiated cost growth and those without. Provide context, key factors driving cost growth as identified through 1:1 conversations.

4. Payers and provider organizations will have the opportunity to see the report and how their performance is presented prior to publication (e.g. review process, embargoed copies of the report prior to release, etc.). Payers and provider organizations will have already seen their own performance throughout steps 1 and 2.

4.2 PUBLIC HEARINGS

1. OHA and the Oregon Health Policy Board (OHPB) will hold public hearings annually, as per SB 889, that will highlight the growth in total health care expenditures and examine trends in key

cost drivers across payer and provider organizations, as well as discussing opportunities to address cost drivers.

2. Payer and provider organizations may be called to these public hearings to share best practices in cost containment, or to explain reasons unreasonable cost growth.

Timing: To ensure a robust data validation and analysis process, and time for collaborative review of the results and understanding cost drivers with payers and providers prior to determination, it is likely that the public report and public hearing will happen in the second year following the measurement year.

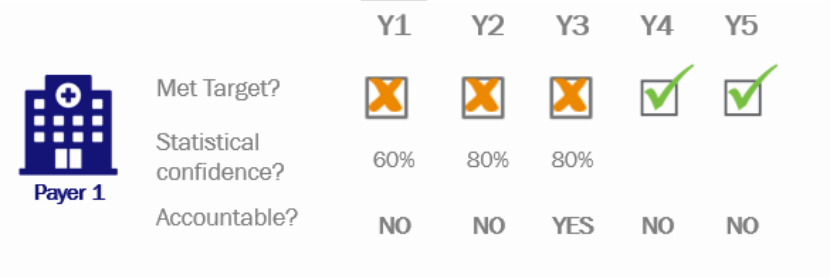
APPENDIX: EXAMPLES

As per the October 6, 2020 Implementation Committee meeting, payers and provider organizations will be held accountable for their cost growth relative to the target based on statistical confidence.

This section builds on examples from the October 6th meeting materials to illustrate the interactions between testing for statistical confidence to determine accountability across multiple years and aligns with Step 1.4 above. These examples apply to both payers and provider organizations.

Example 1

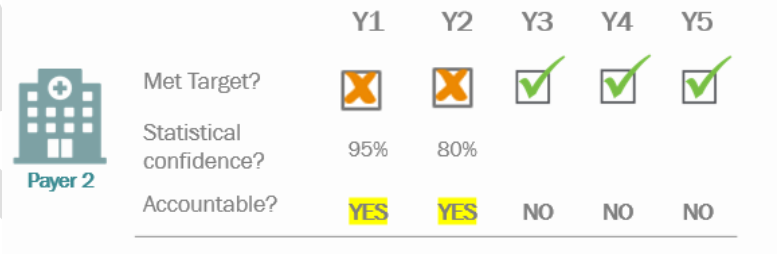
In this example, the payer or provider organization does not meet the statistical testing criteria for accountability until the third year (exceeding the cost growth target at 80% confidence for two consecutive years).



The organization would not have the one-on-one conversation about whether their cost growth was reasonable or not until Y3. If their cost growth in Y3 was found to be unreasonable, they would be put on a performance improvement plan based on Y3.

Example 2

In this example, the payer or provider organization exceeds the cost growth target at 95% confidence in the first year and would immediately have a one-on-one conversation to determine if their cost growth was reasonable or not.



If their cost growth in Y1 was found to be unreasonable, they would be put on a performance improvement plan based on Y2.

If they exceed the cost growth target in Y2, this leads to another round of conversations to determine if their Y2 cost growth was reasonable or not (exceeds the target at 80% confidence or higher for two consecutive years).

If their cost growth was reasonable in Y2, no new accountability mechanisms would apply and they would continue working on their PIP from Y1 (if a multi-year PIP). If their Y2 cost growth was not reasonable, their Y1 PIP would be amended or a new Y2 PIP would be established (e.g. if the cost drivers that led to exceeding the target in Y2 were different than Y1).

Example 3

This payer or provider organization does not have a conversation about whether their cost growth was reasonable or not until Y5 (triggered by two consecutive years of not meeting the target at 80% confidence).

If their Y5 cost growth was unreasonable, they would be put on a performance improvement plan.

Example 4

This payer or provider organization does not ever meet the statistical testing criteria for accountability and does not have any conversations about reasonable costs.

No accountability mechanisms are applied.